EXHIBIT B

AIG

Life Insurance Application
Part B (Medical History)
Policy # (if known): 4209668408

☒ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

(Complete separate Part B for each Proposed Insured.)

First Name	MI	Last Name	Date of Birth	Social Security #
BOB	W	RUTLEDGE	[redacted]	[redacted]

Medical History

(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)

1. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). *(If no personal physician, provide name, address and phone number of last doctor consulted or medical facility visited or to which admitted.)*

Name LORI CREAGAN Phone _____

Address _____ City, State BURNSVILLE MN ZIP _____

Date of last office visit, reason, findings and treatment: DATE: 2020, REASON: PHYSICAL, FINDINGS: NORMAL, TREATMENT: NA

FACILITY INFORMATION PRINTED ON THE SUPPLEMENT

2. Pending Medical Appointments

Does the Proposed Insured have a medical appointment scheduled within the next three months? ..... ☐ yes ☒ no

(If yes, provide date, name, address and phone number of physician, and reason for visit.) _____

3. Build

A. Admitted Height and Weight 5 ft 06 in 184 lbs
(Examiners: Also record measured height and weight on Exam page 1.)

B. Birth Weight (if Proposed Insured is less than 1 year old) _____ lbs _____ oz

C. Has the Proposed Insured had any weight change in excess of 10 lbs in the **past year**? ..... ☒ yes ☐ no
If yes, complete the following: Loss 14 lbs Gain _____ lbs Reason* LOSS: DIET/EXERCISE

*If weight change was due to pregnancy, provide due/delivery date and pre-pregnancy weight:
Due/Delivery Date _____ Pre-Pregnancy Weight _____ lbs

4. Family History

A. Complete the information in the grid below.

Age if Living	Age at Death	Cause of Death	History of heart disease treated or diagnosed by a member of the medical profession (Coronary Artery Disease or Heart Attack)?	History of cancer treated or diagnosed by a member of the medical profession?
Father 73			☒ no ☐ yes Age of Onset _____ Details _____	☒ no ☐ yes Age of Onset _____ Type _____
Mother	61	CANCER	☒ no ☐ yes Age of Onset _____ Details _____	☐ no ☒ yes Age of Onset 51 Type LYPHOMA
Siblings 50			☒ no ☐ yes Age of Onset _____ Details _____	☒ no ☐ yes Age of Onset _____ Type _____

B. Other than as stated in 4A, has any immediate family member of the Proposed Insured (parents, siblings or children), been diagnosed with heart disease prior to age 50, Amyotrophic Lateral Sclerosis (ALS), polycystic kidney disease, porphyria, cardiomyopathy, sickle cell anemia, Huntington's disease, aneurysm, or cancer? ☐ yes ☒ no

(Please provide details including type, age of onset, and relationship(s) to Proposed Insured.)

Details:

C. Is there a family history (parents and siblings only) of mental illness, suicide, or substance abuse, any of which was diagnosed or treated by a member of the medical profession? ☐ yes ☒ no

(Please provide details including diagnosis and relationship(s) to Proposed Insured.)

Details:

5. Personal Health History

A. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) high cholesterol? ☐ yes ☒ no
Date of diagnosis _____ most recent level _____treatment _____

2) high blood pressure? ☐ yes ☒ no
Date of diagnosis _____ most recent reading _____treatment _____

3) diabetes? ☐ yes ☒ no
Date of diagnosis _____ most recent HgbA1c _____treatment _____

B. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) coronary artery disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, or other disorder or disease of the heart? ☐ yes ☒ no

2) blood clot, clotting disorder, aneurysm, stroke, transient ischemic attack (TIA), peripheral vascular disease, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☒ no

3) cancer, leukemia, lymphoma, tumors or growths, masses, cysts or other similar abnormalities? ☐ yes ☒ no

4) pituitary, thyroid, adrenal, or disease or disorder of any other glands? ☐ yes ☒ no

5) anemia, hemophilia, sickle cell anemia, or other disease or disorder of the blood, lymphatic system or immune system? ☐ yes ☒ no

6) colitis, Crohn's disease, hepatitis, colon polyps, or any disorder of the throat, esophagus, gall bladder, stomach, liver, pancreas or intestine? ☐ yes ☒ no

7) disorder of the kidneys, bladder, prostate or reproductive organs or protein or blood in the urine? ☐ yes ☒ no

8) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea or other breathing or lung disorder? ☒ yes ☐ no

9) seizures, cerebral palsy, Down syndrome, autism spectrum disorder, Parkinson's disease, multiple sclerosis, severe headaches, disorder or injury of the brain, spinal cord or nervous system? ☐ yes ☒ no

10) attention deficit hyperactivity disorder (ADHD), memory loss, dementia or Alzheimer's disease? ☐ yes ☒ no

11) anxiety, eating disorder, depression, suicide attempt, bipolar disease, post-traumatic stress disorder (PTSD), hallucinations, psychosis, schizophrenia, or other psychiatric conditions? ☐ yes ☒ no

12) arthritis, muscle disorders, Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, muscular dystrophy, chronic pain, connective tissue disease, autoimmune disease or other bone or joint disorders? ☐ yes ☒ no

13) glaucoma, macular degeneration, optic neuritis or any disorder of the eyes, ears or skin? ☐ yes ☒ no

(For any yes answers, provide details such as: date of diagnosis, date of last treatment; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details 8.A. ASTHMA, DIAGNOSIS DATE: 1988, NUMBER OF ATTACKS IN THE LAST YEAR: 0, WHAT PRECIPITATES SYMPTOMS OR ATTACK?: 0, TREATMENT DATE: 2020, DOCTOR: LORI CREAGAN, BURNSVILLE, MN, FACILITY: FAIRVIEW, USA, TESTS PERFORMED: NO, MEDICATIONS: ALBUTERAL, DOSAGES: 108 MCG, FREQUENCY: PRN, ADVAIR DISK, DOSAGES: 250MCG, FREQUENCY: PRN, HOSPITALIZATION REQUIRED: NO, ER VISIT REQUIRED: NO, TREATMENT: NA.

C. **Other than previously stated,** has the Proposed Insured taken any medications, had treatment or therapy or been under medical observation within the **past 12 months**? ☐ yes ☒ no

(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

D. Within the **past 5 years**, has the Proposed Insured used alcoholic beverages? ☐ yes ☒ no

If yes, Average number of drinks per week _____ Maximum number of drinks per day _____

Type (Beer, Wine, Liquor) _____ Date of last use _____

E. Has the Proposed Insured **ever**:

1) used cocaine, heroin, methamphetamine, hallucinogens, stimulants or any other habit-forming drug except as prescribed by a medical professional? ☐ yes ☒ no

2) used marijuana (prescribed or otherwise) in any form? ☐ yes ☒ no

3) used a controlled substance or prescription drug in a manner other than prescribed by a physician? ☐ yes ☒ no

4) sought or received medical advice, counseling or treatment by a medical professional to discontinue or reduce the use of alcohol or drugs, including prescribed controlled substances? ☐ yes ☒ no

If answered "Yes" to E1 through E4, please provide details below.

Type of drug(s) and/or alcohol _____ Date last used _____

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Amount typically used: _____

Name(s) of doctor/facility _____ Phone _____

Address _____ City, State _____ ZIP _____

Treatment Dates _____

Support group(s) _____

Was treatment or support group attendance court ordered? ☐ yes ☐ no

Details of any drug or alcohol related arrests _____

F. Has the Proposed Insured **ever** tested positive for the Human Immunodeficiency Virus (HIV) or been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☒ no

(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor.)

Details _____

G. Other than previously stated, in the **past 5 years**, has the Proposed Insured:

1) been hospitalized, consulted a member of the medical profession or had any illness, injury or surgery? ☐ yes ☒ no

2) been advised by a member of the medical profession concerning any abnormal diagnostic test results, been advised to see a specialist, or been advised to have any diagnostic test, hospitalization, surgery, or treatment that was NOT completed (except for those tests related to the Human Immunodeficiency Virus), or does the proposed insured have any test results pending? ☐ yes ☒ no

3) undergone any self-administered laboratory test prescribed by a member of the medical profession other than those for pregnancy or Human Immunodeficiency Virus (HIV)? ☐ yes ☒ no

4) made a claim for or received benefits, compensation, payment or pension for any injury, sickness, disability, or impaired condition? ☐ yes ☒ no

(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details _____

H. Has the Proposed Insured had any emergency room, emergency clinic, walk-in clinic, or free clinic visits during the **past 5 years**? ☐ yes ☒ no

(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)

Details_____

I. Has the Proposed Insured **ever** been advised to or chosen to enter a nursing home, hospice, or assisted living facility? ☐ yes ☒ no

(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)

Details_____

J. Within the **last 2 years** has the Proposed Insured:

1) been diagnosed or treated by a member of the medical profession for fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing, or shortness of breath? ☐ yes ☒ no
2) received home health care services, physical therapy or rehabilitation therapy? ☐ yes ☒ no
3) required the use of a cane, walker, wheelchair, other assistive device, or resided in an assisted living facility? ☐ yes ☒ no
4) required assistance or supervision with or had any limitations in performing any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)? ☐ yes ☒ no
5) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside of the home or preparing meals? ☐ yes ☒ no

(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details_____

K. Within the **last 5 years** has the Proposed Insured been treated for or been diagnosed by a member of the medical profession for any other medical, physical, or psychological condition **NOT** disclosed above? ☐ yes ☒ no

(If yes, list condition and details such as: date of first occurrence; symptoms; and how treated.)

Details_____

Agreement and Signatures

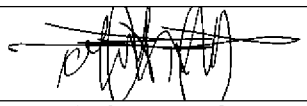
I, the Proposed Insured signing below, acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Fraud

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURE OF PROPOSED INSURED

Signed at *(city, state)* LAKEVILLE, MN On *(date)* 1/4/2021

X 

(If under age 16, signature of parent or guardian)

SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part B application.

If Agent recorded information

Writing Agent Name *(Please print)* | Writing Agent # | Date

X

Writing Agent Signature

If Tele-interviewer recorded information

Name *(Please print)* | Company | Date

If Paramedical Examiner/Medical Doctor recorded information

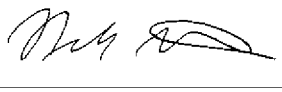
Examiner Address 3030 HARBOR LN 130, PLYMOUTH, MN 55447

Examiner Phone # 763 746-3737

Examiner Name NICOLE JOERNDT

Paramed: Use company stamp below.

APPS
29
3030 HARBOR LN 130, PLYMOUTH, MN 55447
763-746-3737

X 

Examiner Signature

Date 1/4/2021

EXAMINATION
Physical Measurements

1. Proposed Insured

A. _____ _____ _____
First Name MI Last Name

B. Build: Measured Height *(in shoes 1in heel or less)* _____ ft _____in Measured Weight *(clothed)*_____lbs

1) Did you measure the Proposed Insured's height..... ☐ yes ☐ no

2) Did you weigh Proposed Insured? ..... ☐ yes ☐ no

3) If unable to obtain measured height or weight, please provide reason _____

C. Blood Pressure and Pulse
Blood Pressure: Three readings required, spaced at least five minutes apart.
Pulse: Only required once if heart rate between 50-100 bpm, otherwise obtain three measurements.
Select cuff size: ☐ Standard BP cuff ☐ Large BP cuff

	1st Reading	2nd Reading	3rd Reading
Systolic BP			
Diastolic BP			
Pulse Rate			
Irregularities Per Min.			

D. Have any of the following been completed in conjunction with this exam? ☐ Blood ☐ Urine ☐ EKG

E. Examiner observations and remarks

1) Is appearance unhealthy or older than stated age?..... ☐ yes ☐ no
2) Are there any obvious physical abnormalities?..... ☐ yes ☐ no
3) Did anyone assist the Proposed Insured in answering any questions?..... ☐ yes ☐ no
4) Does Proposed Insured use any device to aid in locomotion (e.g. cane, walker, wheelchair)? ..... ☐ yes ☐ no
5) Does Proposed Insured use any other assistive device not previously disclosed (e.g. oxygen, prosthetic limb)? ... ☐ yes ☐ no
6) Does Proposed Insured seem confused, disoriented or otherwise impaired?..... ☐ yes ☐ no
7) Does Proposed Insured have any speech difficulties or use a voice prosthesis?..... ☐ yes ☐ no
8) Was this appointment conducted in a language other than English? (if yes, indicate language and who provided interpretation or translation services) ..... ☐ yes ☐ no
9) Do you have any pertinent information or observation not previously disclosed? ..... ☐ yes ☐ no

Details_____

_____

_____

F. Are you related to the Proposed Insured by blood or marriage or do you have a business or professional relationship with the Proposed Insured? *(If yes, explain)* ..... ☐ yes ☐ no

_____

_____

Report By Examining Medical Doctor

Instructions to doctor:
To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart
   a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? ..... ☐ yes ☐ no
   b. Is heart enlarged? *(If yes, describe)*_____ ☐ yes ☐ no
   c. Is murmur present? *(If yes, complete question d)*..... ☐ yes ☐ no
   d. Murmur is:
      ☐ Constant Transmitted to where?_____
      ☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere
      ☐ Systolic *(Give details)* _____
      ☐ Diastolic Murmur grade: *(Please circle)* 1/6 2/6 3/6 4/6 5/6 6/6
      After valsalva, murmur is:
      ☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

   Your impression _____

_____

_____

Report by Examining Medical Doctor *(continued)*

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction)*.... ☐ yes ☐ no

Details _____

b) Endocrine system *(including thyroid)*?..... ☐ yes ☐ no

Details _____

c) Nervous system *(including reflexes, gait, paralysis)*? ..... ☐ yes ☐ no

Details _____

d) Respiratory system?..... ☐ yes ☐ no

Details _____

e) Abdomen *(including scars)*?..... ☐ yes ☐ no

Details _____

f) Genito-urinary system?..... ☐ yes ☐ no

Details _____

g) Skin *(including scars)*, lymph nodes, blood vessels?..... ☐ yes ☐ no

Details _____

h) Musculoskeletal system *(including spine, joints, amputations, deformities)*? ..... ☐ yes ☐ no

Details _____

Signature

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the _____ day of _____ , 20 _____, at _____ ☐ am ☐ pm

Location of Exam _____ **Paramed: Use company stamp below.**

Examiner Address _____

Examiner Phone # _____

Examiner Name _____

Examiner Signature **X** _____

(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion)

AIG

Addendum to Application

Policy # (if known): 4209668408

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This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)*: See Section(s) Below

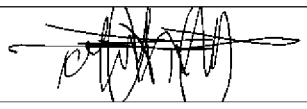
Primary Proposed Insured

First Name BOB MI W Last Name RUTLEDGE SSN [redacted]

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

1. PERSONAL PHYSICIAN'S FACILITY: FAIRVIEW, USA.

Primary Proposed Insured (PPI) Signature

X 

PPI signed on (date) 1/4/2021

Other Proposed Insured (OPI) Signature

X

OPI signed on (date) _____

Owner Signature

X

(If other than Primary Proposed Insured)

Owner signed on (date) _____